MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

September 30, 2005

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: File Code CMS-1502-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled: *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006*, Vol. 70, No. 151, pages 45764-46064 (August 8, 2005). We appreciate your staff's ongoing efforts to administer and improve the payment systems addressed in the rule, particularly considering the agency's competing demands. We have comments on several issues addressed in the proposed rule, and where applicable we have included the captions specified in the rule.

Comments about "Practice Expense"

CMS proposes a substantial change in the method currently used to derive direct practice expense (PE) relative value units (RVUs). The agency proposes to revise the method to calculate direct PE RVUs from the current "top-down" cost allocation method to a "bottom-up" method. Under the bottom-up method, CMS has proposed summing the costs of the resources—nonphysician clinical labor, medical equipment, and medical supplies—obtained from the Clinical Practice Expense Panel (CPEP) inputs refined by CMS and the American Medical Association (AMA). The agency proposes to continue to derive indirect PE RVUs using a top-down method.

We share the concerns that motivated CMS to propose this change:

- The SMS data currently used to derive PE RVUs is dated.
- The current method to derive PE RVUs is complex.
- The current method may result in large fluctuations in the payment for a given service from year-to-year.

Our comments center on four issues: the content of CMS's impact analyses, the process of maintaining the resource inputs over time, the sources of data that CMS will use to derive indirect PE RVUs, and CMS's assumptions used to estimate the cost of medical equipment for imaging procedures.

CMS routinely assesses the impact of major proposed changes on the Medicare allocated charges by physician specialty group but does not routinely assess the impact of proposed changes by groups of services—evaluation and management services, major procedures, other procedures, laboratory tests, and imaging services. To more completely assess the impact of proposed changes, the agency should routinely include such an analysis in its impact analyses. Assessing the impact of proposed changes by groups of services would be more meaningful than assessing the impact only for selected individual services or by physician specialty group.

The process of maintaining the direct resource inputs should aim to reflect efficient providers' costs. CMS relies on advice from the AMA and national medical specialty societies to refine both the direct resource inputs and the work RVUs. MedPAC has raised concerns that these processes are not well designed to consider possibly overvalued services. We are currently exploring ways to refine this process and hope to provide advice to the agency in the future.

Obtaining current and accurate indirect practice expense data is a critical issue facing Medicare. In 2006, CMS proposes to derive indirect PE RVUs using dated SMS data for most specialty groups. The SMS data reflects practice patterns from the 1990s, and was not initially intended to derive PE RVUs. The AMA does not plan to conduct this survey at this time. Therefore, the Secretary will need to consider potential methods and sources for obtaining more recent indirect practice expense data. In a related issue, CMS will use practice expense data submitted by 13 specialty groups to derive indirect PE RVUs. We are concerned about the potential inequity in using more recent data on total indirect practice expenses for some but not all specialty groups.

Finally, we are concerned that the assumptions used to estimate the cost of equipment for imaging procedures may no longer be accurate. The cost of equipment used for a specific service is a function of the equipment's estimated cost per minute and the number of minutes it is employed for that service. When estimating the cost per minute of each type of equipment, CMS assumes that equipment is used 50 percent of the time (Federal Register, June 18, 1997, Vol. 62, No. 117). Rapid growth in the volume of diagnostic imaging services, along with evidence we have seen that most imaging centers operate at least 40 hours per week, suggest that imaging equipment may be used at greater than 50 percent capacity. (As capacity increases, the cost per minute declines because the equipment's fixed cost is spread across a greater number of minutes.)

In addition, CMS's estimate of the number of minutes a piece of equipment is used for an imaging service may not reflect advances in technology that reduce the time it takes to perform a procedure. For example, the replacement of single-slice computed tomography scanners with faster multislice scanners has reduced scan time and led to major improvements in productivity (Jhaveri, K.S., S. Saini, L.A. Levine, et al. 2001. Effect of multislice CT technology on scanner productivity. *American Journal of Roentgenology* (October): 769-772). We plan to examine these issues, and suggest that CMS examine them as well.

Comments about "Geographic practice cost indices"

CMS proposes a modest change in the policy on geographic practice cost indexes (GPCIs). The GPCIs vary among 89 payment localities and account for differences among geographic areas in physicians' practice costs. In response to a request from the California Medical Association, the proposal is to change one of the nine localities in California and to remove from it two counties—Santa Cruz and Sonoma—and designate each of those counties as a distinct locality.

While MedPAC has not taken a position on the specific locality change in the proposed rule, the Commission has a concern about payment localities generally. Our concern is that the locality boundaries have not had a complete review since 1997. In the interim, economic and population trends are likely to have changed the market areas for inputs used in furnishing physician services. If the localities are now inconsistent with those market areas, Medicare is overpaying in some areas and underpaying in others. As discussed in our June 2005 report to the Congress, such an outcome is a form of mispricing of services. Mispricing makes payments inequitable and may have implications for the volume of physician services. MedPAC is working on these issues and encourages CMS to do so also with a goal of revisiting the boundaries of all payment localities, not just those in California.

Comments about "ESRD-Pricing Methodology"

CMS proposes to base payment for drugs separately billed by freestanding facilities and erythropoietin for hospital-based facilities using average sales price (ASP) data. We agree with CMS's proposal to use ASP data to base payment. Over the long term, the agency should set a payment rate that reflects efficient providers' costs. MedPAC recommended that the Secretary periodically collect acquisition cost data from a sample of providers and compare it to the ASP data. By periodically collecting data on providers' costs, the agency can make adjustments as necessary in the ASP level.

CMS proposes to continue to pay reasonable cost for drugs other than erythropoietin furnished by hospital-based facilities. Continuing to pay freestanding and hospital-based facilities differently for providing the same services is not consistent with paying the costs incurred by efficient providers who furnish appropriate care, regardless of the care setting. MedPAC has recommended that the Secretary use the same method to pay for all drugs regardless of setting or type and that the Congress equalize the composite rate for freestanding and hospital-based providers. We recognize that a change in the statute is necessary to eliminate differences in paying for composite rate services between provider types. MedPAC encourages the Secretary to offer a legislative proposal to the Congress that would eliminate this payment difference. In the next section, we discuss two options for the agency to pay the same amount for injectable drugs furnished by both provider types.

Comments about "ESRD Drugs and Biologicals"

The MMA requires that CMS calculate an add-on payment to the composite rate, which represents the difference between pre- and post-MMA spending for dialysis injectables. CMS initially proposed to set the add-on payment at 8.1 percent of the composite rate in 2006. CMS derived this rate using 2003 claims data. Due to a mathematical error, the agency recalculated the add-on payment and now proposes that the payment be set at 10.4 percent of the composite rate. Our analysis using 2003 claims agree with CMS's corrected add-on payment of 10.4 percent.

The MMA also requires that CMS update the add-on payment to account for the growth in separately billable drugs between 2005 and 2006 if pre-MMA payment policies still applied. CMS proposes an update factor of 0.8 percent and a total add-on payment of 11.3 percent in 2006. The add-on payment should not be treated separately from the composite rate. Linking the add-on payment to pre-MMA spending presents problems because previous payment policies provided incentives for the inappropriate use of the drugs. MedPAC recommended that the Congress combine the two rates and we encourage the Secretary to offer a legislative proposal to the Congress that would do so. In addition, an annual review of rates is essential for dialysis, especially given the current low margins.

As noted earlier, CMS is not changing the current cost reimbursement for drugs other than erythropoietin for hospital-based facilities because data on dosing units for the drugs these facilities furnish is not available. We agree with CMS's conclusion about the lack of availability of dosing data from claims submitted by hospitals. MedPAC tried to derive the payment per unit data from hospital claims and were unsure of their accuracy because Medicare does not reimburse hospitals based on the number of units reported on the claim.

To address this need for additional data, MedPAC recommended that the Secretary collect data on the acquisition cost and payment per unit for drugs other than erythropoietin that hospital-based providers furnish. The Secretary could collect this data in the OIG's second study on dialysis drug issues, due to the Congress on April 1, 2006.

If the agency wants to obtain the data sooner, CMS could consider using the unit dosing information obtained from claims submitted by freestanding dialysis facilities. Unlike hospital-based facilities, Medicare's payment to freestanding providers is based on the number of units furnished to beneficiaries. If CMS pursues this approach, the agency should consult with clinical experts about the appropriateness of the dosing data reported by freestanding facilities.

Comments about "ESRD-Composite Payment Rate Wage Index"

The Commission supports CMS's proposal to revise the ESRD composite payment rate wage index using OMB's newly defined Core-Based Statistical Areas (CBSAs). MedPAC has stated that the wage index used in a payment system should be based on market wage rates for occupations typically used in furnishing the service. In the absence of these data, the Commission supports CMS's proposal to calculate wage indexes for each CBSA based on acute care hospital wage and employment data for FY 2002. As the current wage index relies on labor market area definitions and wage data that are 25 years old, CMS's proposed revisions should improve the accuracy of Medicare's payments.

MedPAC has taken the position that geographic payment adjustors should not be artificially constrained by the application of floors and ceilings. We share CMS's concern about the adverse effects that immediately removing the wage index floor could have on access to care for ESRD beneficiaries. Thus, CMS's proposal to phase out the wage index floor seems prudent. CMS proposes to eliminate the wage index ceilings in 2006. It would be more consistent and equitable for CMS to phase out the wage index ceilings instead of eliminating them in 2006.

CMS expects that the change in wage index policy will have a negative impact on aggregate payments to freestanding facilities. That is all the more reason for CMS to seek legislation to eliminate the $4 difference in the base composite rate between freestanding and hospital-based facilities.

Comments about "Multiple procedure reduction for diagnostic imaging"

When multiple imaging procedures are performed on contiguous body parts in the same session, CMS proposes to reduce the technical component payment for the additional procedures by 50 percent. We strongly support this proposal, which is consistent with a recommendation we made in our March 2005 Report to the Congress. We agree that there are savings in clerical time, technical preparation, and supplies when multiple studies are performed on adjacent parts of the body during the same encounter. Currently, the technical component payment rates for imaging services do not account for these efficiencies; the rates assume that each service is done independently. Thus, it is appropriate for CMS to make this payment adjustment when multiple imaging studies are performed. However, CMS proposes to make this adjustment budget neutral, preventing potential budgetary savings and lower cost sharing for beneficiaries. We acknowledge that CMS is legally required to make this adjustment budget neutral, but we encourage the Secretary to offer a legislative proposal to the Congress to capture the potential savings for the program and its beneficiaries. We also plan to pursue such a change.

Comments about "Therapy Cap"

The annual per beneficiary limits on program payments for outpatient physical therapy and speech and language pathology services and a separate limit on occupational therapy become effective on January 1, 2006. The proposed rule states that CMS will publish the final limit amounts when the inflation factor has been finalized, estimating that each limit will be about $1,750. The Commission is concerned about the growth and variation in Medicare' spending on outpatient therapy. In CMS' letter to the Commission in March 2005 outlining the estimates of the 2006 physician fee schedule update, CMS noted that minor procedures, which included therapy services, were an important source of the 2004 spending growth. Over the coming year, the Commission will analyze the variation and growth in program expenditures as ways to assess whether the current therapy cap design is the best policy option to ensure that beneficiaries get the services they need while, at the same time, constrain volume growth.

Comments about "Nuclear Medicine Services"

We strongly support the proposal to include nuclear medicine services in the definition of radiology services under the Stark law (Section 1877 of the Social Security Act). This proposal is justified because physician groups such as the American College of Radiology and the American Medical Association consider nuclear medicine to be a subspecialty of radiology. In addition, this policy change would help limit referrals for nuclear medicine services that are based on financial, rather than clinical, reasons.

When physicians invest in facilities providing nuclear medicine services and refer patients to those facilities, there is a financial incentive to increase the use of nuclear medicine services. A 1994 study by the Government Accountability Office found that physicians who were investors in diagnostic imaging centers referred their patients for more nuclear medicine tests than nonowners (Government Accountability Office. 1994. *Medicare: Referrals to physician-owned imaging centers warrant HCFA's scrutiny*, no. GAO/HES-95-2. Washington, DC: GAO. October). In addition to the risk of over-use, physician self-referral to nuclear medicine facilities undermines fair competition among such facilities, because physician investors have a financial incentive to refer patients to the facility they own.

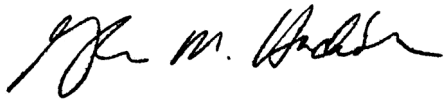
It is reasonable to delay the effective date of this policy to allow physicians who have invested in nuclear medicine facilities an adequate period of time to divest their ownership interests if they wish to continue referring Medicare or Medicaid patients to these facilities. We note that almost all of the provisions in the Stark law final rule (phase I) became effective one year after the rule was published (January 4, 2001). There is no justification, however, to grandfather such arrangements. The Stark law itself does not allow prohibited financial arrangements to be grandfathered. Moreover, the previous rules issued by CMS implementing the Stark law do not permit grandfathering. Given the number and variety of settings in which nuclear medicine services are available (such as hospitals, freestanding centers that are not owned by physicians, and physician offices), we expect that a prohibition on physician investment in nuclear medicine facilities to which they refer patients would not decrease beneficiaries' access to care.

Comments about "Sustainable Growth Rate"

In this section of the proposed rule, you state that in addition to providing adequate payments, Medicare's physician payment system should encourage physicians to provide quality care and prevent avoidable health care costs. We are pleased that your proposed rule supports MedPAC's recommendations to develop quality and efficiency measures related to providing physician services. MedPAC appreciates your consideration of these comments.

If you have any questions or need clarification, please contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman

GH:cb:j